

HUMAN SERVICES BOARD

# INTRODUCTION

## FINDINGS OF FACT

1. In late October or early November 2002 the Department received a report that the petitioner, a privately employed in-home caregiver, had been accused of neglecting G.C., an elderly and disabled woman in her charge. The Department's investigation culminated in a Commissioner's Review Hearing held on June 27, 2003, after which the Department determined (by notice dated August 5, 2003) that the report of neglect was "substantiated". This appeal followed.

2. After several continuances agreed upon by the parties, a hearing was held on November 16, 2004. At that hearing the Department presented the testimony of two witnesses, its investigator and G.C.'s granddaughter in law, in the latter of whose home G.C. resided, and who was G.C.'s primary caregiver.<sup>1</sup> The petitioner testified in her own behalf.

3. The granddaughter in law testified that G.C. at the time in question was an elderly woman who suffered from severe diabetes and dementia. She was a large woman who was incontinent and whose personal needs required frequent changing, repositioning, and assistance with and monitoring of her food intake. The petitioner was hired (by G.C.'s daughter, the granddaughter in law's mother in law) in February 2002 to provide this care on a regular "respite" basis mostly on weekday afternoons and Saturdays when the granddaughter in law was often out of the home busy with the activities of her own children.

4. The parties agree that the petitioner slept much of the time and was often uncooperative when she was awake. There is also no dispute that the petitioner was aware of

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<sup>1</sup> G.C. had died sometime between the events in question and the time of the hearing.

G.C.'s diabetes condition and that she understood the need to supervise and monitor G.C.'s food intake.

5. The granddaughter in law testified that on the weekend day in question in October 2002 she returned to the home after G.C. had been in the petitioner's care for several hours in the afternoon. She stated that when she arrived home the petitioner was seated outside G.C.'s room and that G.C.'s door was shut tight. She stated that after a brief conversation with the petitioner, during which the petitioner did not indicate any problems with G.C., the petitioner left the home and she went in to check on G.C.

6. She testified that she found G.C. "totally unresponsive" and lying in cold urine-soaked clothing and bed sheets and blanket. She stated that she then found G.C.'s blood sugar level to be alarmingly low, which prompted her to call the doctor, who gave her instructions to immediately get some food into G.C. Fortunately, G.C. soon recovered, but the granddaughter in law reported the incident to G.C.'s daughter (her mother in law), who promptly fired the petitioner.

7. At the hearing the petitioner testified that shortly after she arrived for work on the afternoon in question she fed G.C. a grilled cheese sandwich. She stated that her

"normal protocol" was to check on G.C. every 15 minutes "maximum" and to reposition and change her every two hours. The petitioner stated that she only worked three hours on the day in question and that she (the petitioner) had been "upset" that day over a personal matter. She could not say whether she had changed G.C. at all that day, but she testified that she had checked in on G.C. shortly before the daughter in law had returned, and that G.C. was "sleeping as usual" and did not appear to have been in any distress. She stated that she was "fanatical" about G.C.'s care and that she wouldn't have "knowingly" left G.C. in a "soaked state".

8. The Department's investigator testified that during the course of his investigation in November 2002 he interviewed the petitioner, who told him that she may not have turned or changed G.C. at all that day because of "personal problems" she herself was having. He also stated that the petitioner told him that although she had fed G.C. a cheese sandwich, it had been a "poor feeding day". He also testified that the petitioner told him she was a "licensed nurse", but that her license is currently "inactive".

9. At the hearing the Department introduced evidence that in 1991 the petitioner had stipulated with the Vermont Board of Nursing that the Board could find that she had

engaged in "unprofessional conduct" by fraudulently obtaining a patient's prescription medication, and that the Nursing Board was thereby revoking her LPN license as of that date.<sup>2</sup>

10. The hearing officer finds all the above testimony by G.C.'s granddaughter in law and the Department's investigator to be credible. Based on this testimony, and on the admissions of the petitioner that she was having personal problems and may not have changed and repositioned G.C. for three hours on the day in question, it is found that the petitioner neglected to adequately feed G.C. and to visually check on G.C.'s status for several hours on that day, causing G.C. to lie for an inordinate and unhealthful amount of time in urine-soaked clothes and bedding and allowing G.C. to lapse into an unresponsive state due to lack of sufficient care and nourishment.

11. The evidence regarding the revoked status of the petitioner's nursing license is deemed admissible solely for the purpose of impeaching the petitioner's overall credibility in that it contradicts, or at least renders highly misleading, the statement she made to the Department's investigator that her license was simply "inactive". Even

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<sup>2</sup> The petitioner vigorously objected to the admission of this evidence.

without this evidence, however, the petitioner's testimony that she regularly checked on G.C.'s condition on the day in question, and that shortly before she left work she had observed that G.C. was neither unresponsive nor urine-soaked, is found to be incredible. It is further found that the petitioner, by her training, experience, and specific job instructions, was fully aware that failure to check G.C.'s condition, supervise and monitor her food intake, and change her clothes and bedding would likely lead G.C.'s health, comfort, and well-being to suffer.

ORDER

The Department's decision is affirmed.

REASONS

The Commissioner of the Department of Aging and Independent Living is required by statute to investigate reports regarding the abuse and/or neglect of elderly and disabled persons and to keep those reports that are substantiated in a registry under the name of the person who committed the abuse and/or neglect. 33 V.S.A. § 6906, 6911(b). Persons who are found to have committed abuse and/or neglect may apply to the Human Services Board pursuant

to 33 V.S.A. § 6906(d) for relief on the grounds that the report in question is "unsubstantiated".

The statute which protects elderly adults, 33 V.S.A. § 6902, defines "neglect" as follows:

As used in this chapter:

(9)"Neglect" means the lack of subsistence, medical or other care necessary for well-being.

As found above, credible evidence in this case establishes that the petitioner, while engaged in her work as G.C.'s personal caregiver, failed for several hours to change G.C.'s clothing and bedding and failed to oversee and monitor G.C.'s food intake, allowing G.C. to lapse into a state of unresponsiveness and lie for an inordinate and unhealthful amount of time in urine-soaked clothes and bedding. Thus, it must be concluded that the petitioner's actions (or inaction) in this case constituted "neglect" of an elderly and disabled person within the meaning of the above statute. The Department's decision must, therefore, be affirmed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 17.

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